



Connecticut General Assembly – Insurance and Real Estate Committee
Public Hearing – March 18, 2021
HB 6622

Testimony of Laura Hoch,
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Senator Lesser, Representative Wood, Senator Hwang, Representative Pavalock-D’Amato and members of the Insurance and Real Estate Committee, thank you for the opportunity to submit testimony on HB 6622, An Act Concerning Prescription Drug Formularies and Lists of Covered Drugs, and how it may impact individuals living with multiple sclerosis (MS).

MS is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms vary from person to person and range from numbness and tingling to walking difficulties, fatigue, dizziness, pain, depression, blindness, and paralysis. The progress, severity, and specific symptoms of MS in any one person cannot yet be predicted, but advances in research and treatment are leading to better understanding and moving us closer to a world free of MS. Nearly 1 million people in the United States and 2.3 million worldwide are currently living with MS. When someone is diagnosed with MS, their clinician will typically prescribe a medication referred to as a disease-modifying therapy (DMT). DMTs are used to modify the disease course, treat relapses, and manage symptoms. Growing evidence indicates that early and ongoing treatment with DMTs is the best way to prevent the accumulation of disability and protect the brain from permanent damage due to MS.

Mid-year formulary changes, often referred to as “non-medical switching”, are changes that health insurers make to prescription drug benefits during the plan year, for reasons that may be unrelated to patients’ health or safety. Insurers can currently make several types of changes to their drug formulary during the plan year, such as moving a prescription to a higher cost-sharing tier, increasing out-of-pocket costs by moving from co-pay to co-insurance, adding utilization review requirements (such as step therapy or prior authorization) or removing a prescription from a drug formulary.

Movement from one DMT to another should only occur for medically appropriate reasons. When a person living with MS loses access to the treatment that best controls their disease progression, they may experience loss of function and possibly irreversible increase in disability. Managing MS can be a difficult process that requires several “trial and error” changes to



medication before finding the one that is most effective at controlling disease progression with the fewest negative side-effects. Once a patient living with MS finds a DMT that works for them, treatment with that medication should continue without interruption unless determined otherwise by the individual or their healthcare provider. Switching for any reason other than medical necessity could lead to hospitalization or lengthy stays at rehabilitation centers, both of which are much costlier than the difference in drug prices.

It is also inherently unfair for one party under contract to make changes during a contract period. When patients enroll in a health plan, they sign a contract for an entire year. People with chronic conditions like MS often base their decision to enroll in a health plan on the available information about the medications they need. MS DMTs are very costly. As of 2020, the brand median price of DMTs was \$91,835 and five of them are priced at more than \$100,00 per year. Placing any DMT on a higher cost-sharing tier during a policy term can create either unmanageable expenses or worsening symptoms and side effects for individuals living with MS due to lack of adherence. A poll by the Alliance for Patient Access found that two-thirds of respondents saw an impact in their ability to work after they were switched and 40% said they were unable to contribute needed family care. 70% said they were left feeling helpless after the switch and nearly 60% reported suffering at least one complication from the switch.¹ Allowing health insurers to remove coverage of a prescription drug or reclassify it to a higher cost-sharing tier during a policy term conflicts with treatment recommendations of leading experts in the treatment of MS.

Insurers' formulary decisions may be based not only on cost-related factors, but on an inaccurate yet commonly held assumption that the available drug treatments for MS are interchangeable. In fact, the complexity of MS, combined with the potential for serious side effects and unique patient characteristics, make the process of identifying the "best" DMT for each patient with MS highly challenging. Experts in the treatment of MS advocate for early, ongoing, and uninterrupted treatment with a DMT following careful assessment by specialists. This cannot occur if patients and doctors are subject to a process that is not transparent. Lack of transparency on costs and barriers to the drug increase the risk that a patient may not be able to afford or access their medication

The National MS Society supports limiting the use of non-medical switching during an insurer's policy term and we therefore support HB 6622. This same legislative language passed the House with strong bipartisan support in the 2019 legislative session and we hope to see it pass

¹ https://admin.allianceforpatientaccess.org/wp-content/uploads/2020/01/AfPA_Qualitative-Impact-of-Non-Medical-Switching_Report_Feb-2019.pdf



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both chambers this year. Interference with a person's course of treatment poses dangerous threats to their health and safety. We do encourage the committee to amend this bill to require that insurers provide notice if they plan to remove a drug from a covered formulary at the end of the policy term. This notice should be given before open enrollment begins so that the insured is aware of changes and can make an informed decision moving forward. We urge you to protect the residents of Connecticut, including those living with MS.

Please contact me if I can be of further assistance: laura.hoch@nmss.org or (860) 913-2550 X52521.